Naval Hospital Oak Harbor Prime Health Center
Six Month Well Child Visit

Date:
Time:

Provider Note

Interval History:

Past Medical History:

Medications:
Allergies:
Immunizations:
Family/Social History Update:

Development: ❒ Sits unsupported ❒ Babbles ❒ Single consonants ("mum","da")
❒ No head lag ❒ Holds Bottle ❒ Transfers objects from hand to hand

Physical Exam

Vital Signs ❒ N/A Pain: ___ (0-10)

Weight: _____ kg _____ lb _____%ile Temp: _____ HR: _____
Length: _____cm _____ in _____%ile RR: _____ O2 Sat: _____
OFC: _____cm _____ in _____%ile

Nl	Abn	
❒	❒	General Appearance:
❒	❒	Head:
❒	❒	Eyes
❒	❒	ENT:
❒	❒	Neck:
❒	❒	Chest:
❒	❒	Heart:
❒	❒	Abdomen:
❒	❒	Genitals:
❒	❒	Musculoskeletal:
❒	❒	Skin:
❒	❒	Neuro:

Assessment

Plan

Anticipatory Guidance
Immunizations: DTaP, Prevnar, Influenza
Other:

Follow-up: 9 months of age other: _____

Addressograph

_____
Examiner's Signature/Name Stamp

Six Month Well Child Visit
Parent Questionnaire

1. Describe your baby's diet:
   - ❒ Breastfeeds _____times per day.
   - ❒ Formula feeds_____ounces per day. Name of Formula: _____
   - ❒ Baby Foods

2. Baby's water source: ❒ City ❒ Well ❒ Bottled

3. Where does your baby sleep? ❒ Crib ❒ Parent's Bed ❒ Other:

4. Who is your baby's main caregiver?

5. Have solid foods been introduced to your baby's diet? Yes/No

6. Has your baby begun drinking from a cup? Yes/No

7. Do you have any concerns about your baby's hearing or vision? Yes/No

8. Do you have any concerns about your baby's development? Yes/No

9. Are there any smokers in the household? Yes/No

10. Is there is a gun in the home? Yes/No

11. Does your home have working smoke detectors? Yes/No

12. Do you put the crib rails up whenever you leave your baby in its crib? Yes/No

13. Do you ever leave your baby alone on tables or beds? Yes/No

14. Do you ever leave your baby alone in the bathtub? Yes/No

15. Have you checked the temperature of the hot water where you live? Yes/No

16. Does your baby ride in a car seat in the back seat, facing backwards? Yes/No

17. Do you have a routine for putting your baby to sleep? Yes/No

18. Does your baby wear a pacifier or jewelry around his or her neck? Yes/No

19. Are you aware of the potential dangers of baby walkers? Yes/No

20. Do you fear for the safety of yourself or members of your family? Yes/No

21. What questions do you have for your baby's provider today?